BLISS DENTAL

Patient Information

Patient Name: _____ Date: _____

Last First MI

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other Email: _____

Social Security#: _____ DOB: ___/___/_____

Phone(Cell): _____ Phone(Home): _____ Phone(Work): _____ Ext ____

Best time to call: _____ Preferred appointment times: ☐AM ☐PM ☐Evening ☐M ☐T ☐W ☐TH ☐FR ☐S

Address: _____

Street Apartment#

_____

City State Zip Code

Office policy: I understand that there will be a $25 cancellation fee charged per patient for any appointments cancelled with less than 24 hours notice. We appreciate your understanding.
Initial X_____

Health Information

Please check those that apply:

☐HIV
☐Allergies_____
_____
☐Anemia
☐Arthritis
☐Artificial Joints
☐Asthma
☐Blood Disease
☐Cancer
☐Diabetes
☐Dizziness
☐Epilepsy
☐Excessive Bleeding
☐Fainting
☐Glaucoma
☐Growths
☐Hay Fever
☐Head Injuries
☐Heart Disease
☐Heart Murmur
☐Hepatitis
☐High Blood Pressure
☐Jaundice
☐Kidney Disease
☐Liver Disease
☐Mental Disorders
☐Nervous Disorders
☐Pacemaker
☐Pregnant: ↓Pls bring
Due_____ OB form
☐Radiation Treatment
☐Respiratory Problems
☐Rheumatic Fever
☐Rheumatism
☐Sinus Problems
☐Stomach Problems
☐Stroke
☐Tuberculosis
☐Tumors
☐Ulcers
☐Venereal Disease
☐Smoking/Tobacco
☐Dry Mouth

Allergies: Circle those that apply: Penicillin, Aspirin, Codeine, Iodine, Latex, Sulfa, Ibuprofen, NONE
OtherAllergies: _____

-Have you been admitted to a hospital or needed emergency care during the past two years? ☐Yes ☐No
If yes, please explain: _____
-Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____
-List of Medications: _____
-Do you have any health problems that need further clarification? ☐Yes ☐No
If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature: _____ Date: _____

Referral Information

Whom may we thank for referring you to our practice? ☐Another Patient_____
☐Dental Office ☐Yellow Pages ☐Newspaper ☐Work ☐Other_____

Name of person or office referring you to our practice: _____

Employment Information

Employer Name:_____ Occupation:_____

Address:_____

Street City State Zip

Responsible Party Information (Please fill out if patient is under 18 years of age)

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other_____

Social Security #: _____ DOB: _____

Phone (Cell): _____ Home: _____ Work: _____ Best time to call: _____

Address: _____

_____

Insurance Information

Primary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's DOB:_____ Member ID#:_____ Group #:_____

Insured's Address:_____

Street City State Zip

Insured's Employer Name:_____

Address:_____

Street City State Zip

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other_____

Insurance Plan Name and Address:_____

_____

Secondary

Name of Insured:_____ Is insured a patient? ☐ Yes ☐ No

Last First MI

Insured's DOB:_____ Member ID#:_____ Group #:_____

Insured's Address:_____

Street City State Zip

Insured's Employer Name:_____

Address:_____

Street City State Zip

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other_____

Insurance Plan Name and Address:_____

_____

I certify that I have answered all questions correctly and to the best of my knowledge. I certify that I and/or my dependent(s), have insurance coverage with_____and assign directly to Bliss Dental LV and its associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services.

I have read the above conditions of treatment and payment and agree to their content.

_____**Date:** _____ **Relationship to Patient:**_____

Signature of patient, parent or guardian

_____**Date:**_____**Relationship to Patient:**_____

Signature of guarantor/responsible party

BLISS DENTAL

Patient Name:_____Date:_____

Dental Questionnaire Form

To better understand your dental needs please fill out this short dental questionnaire form.

Please circle **YES** or **NO** and answer questions as indicated.

1. Do your gums bleed when you brush or floss? **Yes** **No**
2. Do you have earaches or neck pains? **Yes** **No**
3. Are your teeth sensitive to cold, hot, sweets, or pressure? **Yes** **No**
4. Do you have clicking, popping or discomfort in the jaw? **Yes** **No**
5. Does food or floss catch between your teeth? **Yes** **No**
6. Do you Brux or grind your teeth? **Yes** **No**
7. Is your mouth dry? **Yes** **No**
8. Do you have sores or ulcers in your mouth? **Yes** **No**
9. Have you had any periodontal (gum) treatments? **Yes** **No**
10. Do you wear dentures or partials? **Yes** **No**
11. Have you ever had orthodontics (braces) treatment? **Yes** **No**
12. Do you participate in active recreational activities? **Yes** **No**
13. Have you had any problems associated with previous dental treatment? **Yes** **No**
14. Have you ever had a serious injury to your head or mouth? **Yes** **No**
15. Date of your **last** dental exam_____
16. What was done at that time? _____

    _____
17. Date of last dental xrays_____
18. Are you currently experiencing dental pain or discomfort? **Yes** **No**
19. What is the reason for your dental visit today? _____

    _____
20. How do you feel about your smile?_____

BLISS DENTAL LV

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____ have been offered and/or received a copy of this Office's Notice of Privacy Practices.

_____ _____

{Signature} **{Date}**

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgement could not be obtained because (circle one): Individual refused to sign, Communication barriers prevented obtaining acknowledgement, Emergency situation prevented obtaining acknowledgement, Other (specify):

_____

GENERAL DENTISTRY INFORMED CONSENT FOR EXAM

I understand that I am having the following done: Oral Examination & X-rays
_____(initials)

I understand that dentistry is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I understand that each Dentist is an individual partitioned and is individually responsible for the dental care given to me.

I hereby authorize any of the doctors or dental auxiliaries of Bliss Dental LV to proceed with and perform the exams and dental treatment as explained to me.

_____ _____

{Signature} **{Date}**

BLISS DENTAL

FINANCIAL AGREEMENT

Our office is committed to fulfilling our patient's needs by providing exceptional dentistry in a warm and compassionate manner. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by the front staff only. The Doctors have no involvement in making any financial arrangements. Financing is also available upon approved credit. For accounting purposes, young financial arrangements will be confirmed by signed documentation and placed into the patient's chart and a copy will be given to you. To avoid any misunderstandings any changes form the original agreement will require additional signatures.

Returned checks and balances older than 60 days may be subject to additional collection fees and interest charges of 1 ½ % per month. Charges may also be made for broken appointments and appointments cancelled without 24 hours notice.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We will bill your insurance as a courtesy and regardless of what we calculate as our dental benefits, we must stress because your insurance cannot guarantee any benefits to our office, the patient/guarantor will always be responsible for the total treatment fee. We will give your insurance sixty (60) days to pay their share of any fees, any payments not received within that time will become your responsibility. For our Medicaid patients, services not covered by your insurance are collected at the time of service and due when treatment is rendered. It is the patient's responsibility to call their insurance regarding coverage details.

Our financial Coordinator will collect any agreed upon fees before or at the time of treatment. For your convenience, we accept Visa and MasterCard and debit cards. Local checks will be accepted only with proper identification. If any questions or problems arise, we encourage you to contact us promptly for assistance in the management of your account. We are here to help you.

_____ _____

Signature of Patient/Parent/Guardian Date

_____ _____

Print Name Relationship (if other than patient)